HEALTH CARE/EMERGENCY PLAN
(Diabetes)

LAKEVILLE SCHOOLS
HEALTH SERVICES

STUDENT INFORMATION:

STUDENT: ______________________________________SCHOOL_______________________________
DATE OF BIRTH: _________________________________ GRADE: ________
CONTACTS:
Parent/Guardian: ____ Home phone: _______________________
Work #:____ Cell/Pager: _________________________
Physician/Clinic: ____ Phone #:____________________________
Emergency Contact _______________________________Phone #: ________________ Relationship ______________
ALLERGIES: ____

SIGNS AND SYMPTOMS OF LOW BLOOD SUGAR (Check if applicable to your child)
___shaking ___sweating ___hunger ___weakness ___headache ___tingling sensation
___dizziness ___pallor ___fatigue ___confusion ___anxious ___rapid heart beat
___irritability ___yawning ___blurred vision _____ other: ____

PLAN OF CARE:
1. ____ No insulin at school
2. ____ Permission to test blood glucose independently. (E.g. at locker /classroom) Results sent home: _________
3. ____ Supervision of testing/results
4. ____ Student will need assistance with testing and blood glucose management.
5. ____**Blood glucose monitoring**: Times: _______________________ Target range: ________________________
• If < _________________ do this: ____
• If > _________________ do this: ____
• Other special instructions: ____
6. ___ PRN Blood Glucose Testing for symptoms of Hypoglycemia/ Hyperglycemia.
7. ___ **Insulin to be given at school**: Method (syringe, pen, pump, pump with wizard) ________________________
Type: _________________________ Dose: ____________ Time: _____________ Peak: __________
Type: _________________________ Dose: ____________ Time: _____________ Peak: __________
8. ___ Field Trip Plan: ____
9. ___ Snacks: Time: _________________ Type: _____________________ Amount: ________________________
10. ___ Physical Education Class: Time and day scheduled: ____
Snack before: ___ yes ___ no
Test before: ___ yes ___ no
11. ___ Oral Glucose gel (Insta-Glucose, etc.) Give when: ____
12. ___ Glucagon Injection. Given when: ____
13. ___ Follow Bolus Wizard tm settings/dosage calculator program in the insulin pump.
14. ___ Dose calculation based on food intake and current blood glucose (see scale below)
- **Meal bolus____# units of insulin/carbohydrate choice (15GM)**
- **Blood glucose correction scale: ____unit/_____points BG is>150**

Correction bolus may be given with meals or every ____ hours if blood glucose levels are high.
Note: Insulin dose is a total of meal bolus and correction bolus.

Blood Glucose Value	Units of Insulin
Less than 100	
100-150	
151-200	
201-250	
251-300	
301-350	
351-400	
More than 400	

11.___ Ketosticks at school for PRN use. Use if: ____________________
12. ___ Other:
____
____
____
____
____

(OVER)

Confidential

STUDENT: ____

EMERGENCY PLAN OF CARE:
1. If student is unconscious or is unable to swallow:
- **Call 911 immediately**
- **DO NOT give anything to eat or drink**
- **Check blood glucose if below optimal range or symptomatic give:**
- **Give their snack, 4 ounces of juice, 1/3-cup pop (not diet) or 3-4 glucose tablets.**

(If unable to give snack or glucose tablets, give 15 grams of glucose gel.)
- **Call 911 if student does not respond to treatment.**
- **Notify parent/guardian/healthcare provider if, severe low blood sugar reaction does not respond to treatment within 30 minutes.**
- **After treatment and rest, the student should resume his usual schedule, unless Parents or medical providers indicate otherwise.**
- **____May return to class when improvement noted.**
- **Administer prescribed medication.**
- **Criteria met for self- administration of medication (date) ________ Locker # _________ Combo______________**

HOSPITAL OF CHOICE: ____

Nursing Diagnosis	Goals
• Potential for alterations in blood glucose. • Alteration in body requirements • Potential for less than optimal academic achievement due to D.M. • Potential for future complications related to D.M.	• Prevent hypoglycemia and hyperglycemia. • Student will have appropriate caloric intake and exercise program • To coordinate D.M. management with school activities/schedules. • To promote understanding of DM and its Tx.

- **I give the Licensed School Nurse permission to consult (both verbally and in writing) with the above named student's physician regarding any questions that arise about the medical condition and/or medications/treatments/procedures being used to treat the condition. ___yes ___no**

☐ Parent signature: ____Date: _________________

☐ Parent signature: ____Date: _________________

☐ Physician signature*:____Date:__________________

☐ School Nurse: ____Date: _________________

☐ Health Associate: ____Date: __________________

***Physician signature required only if this form is used as a doctor's order for medication(s) or treatment(s)**
*Testing procedures for glucose monitoring and self-administration of insulin will not be done at school without physician and parent's signature.
- The school district intends to use the requested information to provide for your child's health and safety needs while at school.
- You may refuse to supply the requested personal information.
- If this form is not completed it may result in an incomplete health and safety plan for your child.
- The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success. (MS Section 13.04, Subdivision 2)